

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

13884

1. PLACE OF DEATH

County.....
 Township.....
 City.....
 Registration District No. 791
 Primary Registration District No. 1003
 File No. 4569
 Registered No. 4569
 St. Ward)

2. FULL NAME

Alexander Canavera
 (a) Residence. No. 3724 Olive St., 7 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 23 1901

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
21 15 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Stone
 (STATE OR COUNTRY) France

10. NAME OF FATHER Bathista Canavera

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Italy
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Maria Fasseth

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Italy
 (STATE OR COUNTRY)

14. INFORMANT Mr B. Canavera
 (Address) 3724 Olive St

15. FILED 3724 Olive St Mar 6 Starkeoff
 19 1925 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 30 1925

17. I HEREBY CERTIFY That I attended deceased from April 17, 1925, to April 30, 1925, that I last saw him alive on Apr 30, 1925, and that death occurred, on the date stated above, at about 12:00 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia with Empyema
Respiratory failure or embolism
Lobar pneumonia (duration) yrs. mos. ds. 20 ds.
 CONTRIBUTORY Chronic (duration) yrs. mos. ds. 20 ds.
Chronic (duration) yrs. mos. ds. 20 ds.
operation for
He is drinking the
operation
april 30 1925

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: He is drinking the

DID AN OPERATION PRECEDE DEATH? operation
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Pos with drainage chest
 (Signed) Wm W Rainey, M. D
 , 19 (Address) University of Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cem DATE OF BURIAL May 2 1925

20. UNDERTAKER Carl C Calcuthura ADDRESS 1921 Cooper

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

W. G. Evans J

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Alexander Canavera.

Who died at: Deaconess Hosp. on Apr- 30 - 1926.

Residence: No. 37 24- Olive - St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Lobar pneumonia with empyema
Respiratory failure embolism.

Contributory: Lobar pneumonia

Operation for draining the Lungs, Information

Where was disease contracted? given over phone by Dr. W. R. Rainey
11-30-25

Did operation precede death? _____ Date of Leiv. of U. S.

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: _____

Address of physician: _____

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The information is sought for statistical purposes. Prompt return of the information desired will be appreciated. For your reply, an envelope which requires no postage, is inclosed.

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